5 3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 24833
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CLEMENT MIDDLE: E. LAST: ALDERMAN
2a. DATE OF DEATH MONTH DAY YEAR: September 5, 1984
2b. HOUR: 9:18am M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH MONTH DAY YEAR: Sept. 20, 1905
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR MONTHS / DAYS: IF UNDER 24 HRS. HOURS / MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Perry Point, Md.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Contractor
12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: P.G. Co.
13c. CITY OR TOWN: Laurel
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 8615 Portsmouth Dr. / 20708
14. FATHER'S NAME FIRST: Bethel MIDDLE: - LAST: Alderman
15. MOTHER'S MAIDEN NAME FIRST: Allie MIDDLE: - LAST: Parker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
16a. (IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 265-10-3019
17. INFORMANT: Gary Alderman (Son) ADDRESS: Same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Third degree heart block due to arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic congestive heart failure; right pneumonia; cerebral arteriosclerosis; peripheral arteriosclerotic vascular disease

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (X)(this hospital) attended the deceased from July 26, 19 83, to September 5 19 84, XXXXXXX ~~saw the deceased alive on~~ XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: KH Huebner DEGREE: MD. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 9-6-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): K. H. HUEBNER, M.D.
22e. ADDRESS: VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Crematory
23b. DATE: Sept/6/84
23c. NAME OF CEMETERY OR CREMATORY: Chambers Crematory
23d. LOCATION CITY OR TOWN COUNTY STATE: Riverdale, P.G. Co., Maryland
24. FUNERAL DIRECTOR NAME ADDRESS: Chambers Funeral Home, Riverdale, Md.
25a. DATE REC'D. BY REGISTRAR: SEP 13 1984
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

A

18 23 35 16a5 2 1 9 1

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24834
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Madeline MIDDLE: R. LAST: Anson		2a. DATE OF DEATH MONTH DAY YEAR: September 16 1984	2b. HOUR: 1:55a M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 20, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Conowingo	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 592 MacCauley Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Haverford School System
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Conowingo	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS: 592 MacCauley Road 21918
14. FATHER'S NAME FIRST: Howard MIDDLE: H. LAST: Brown		15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: Jane LAST: Nesbitt	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 186-38-7865	17. INFORMANT: Byron H. Anson, ADDRESS: 592 MacCauley Road Conowingo, Maryland 21918	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) CACHEXIA 2° TO MULTIPLE

DUE TO, OR AS A CONSEQUENCE OF (c) MYELOMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): ANEMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-23- 1982 to 8-21 1984, that (I) (we) last saw the deceased alive on 8-21 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 9/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR SANT RAM

22e. ADDRESS: Suite 206, SCMB, Westmont, Pa

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Sept. 19, 1984	23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Drexel Hill Delaware Penna.
24. FUNERAL DIRECTOR NAME: Lee A. Patterson & Son, ADDRESS: Perryville, Maryland		25a. DATE REC'D. BY REGISTRAR: SEP 20 1984	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kundsen

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be contacted immediately.

BP_____

DHMH-16 20M (VRA 15, 4) 7/78

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

84 24835

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 143. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print): First Earnest Middle Leo. Last Blizzard

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☑ Month 9 Day 22 Year 1984 — 2b. HOUR 11 PM

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: 9-10-1918 — 6. AGE (In years last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

2c. DATE PRONOUNCED DEAD: Month 9 Day 23 Year 1984 — 2d. HOUR 9A M

7a. BIRTHPLACE (State or foreign country): Md. — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. COUNTY OF DEATH: Cecil Md.

10. CITY OR TOWN OF DEATH: North East — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 176 Bouchelle Rd. — 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Equip. Oper. — 12b. KIND OF BUSINESS OR INDUSTRY: St. Govt.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. — 13b. COUNTY: Cecil — 13c. CITY OR TOWN: North East — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: 176 Bouchelle Rd. 21901

14. FATHER'S NAME: First Charles Middle Last Blizzard — 15. MOTHER'S MAIDEN NAME: First Mae Middle Last Naill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) — 16b. SOCIAL SECURITY NO.: 220-10-4982 — 17. INFORMANT: Jean Blizzard — ADDRESS: 176 Bouchelle Rd. ~~North East, Md. 21901~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerotic Coronary Vascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 Years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Severe CHRONIC OBSTRUCTIVE LUNG DISEASE and ABDOMINAL AORTIC ANEURISM

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 — 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) — 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry Borkas, MD M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 9/23/84

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 23b. DATE: 9-23-84 — 23c. NAME OF CEMETERY OR CREMATORY: Cratin & Ferris — 23d. LOCATION (City or Town) (County) (State): West Chester Chester Pa.

24. FUNERAL DIRECTOR: Crouch Funeral Home — ADDRESS: North East, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 25 1984 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84

24836
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPH MIDDLE: C. LAST: BLOTKAMP
2a. DATE OF DEATH MONTH DAY YEAR: SEPTEMBER 9, 1984
2b. HOUR: 3:35A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH MONTH DAY YEAR: December 2 1898
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS
IF UNDER 1 YEAR MONTHS: DAYS:
IF UNDER 24 HRS HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Aberdeen
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA MEDICAL CENTER PERRY POINT MD
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): U.S. Army
12b. KIND OF BUSINESS OR INDUSTRY: S.Srgt

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: ---
13c. CITY OR TOWN: Baltimore
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: Fait Ave. 21224
14. FATHER'S NAME FIRST: Valentine MIDDLE: - LAST: Blotkamp
15. MOTHER'S MAIDEN NAME FIRST: Barbara MIDDLE: - LAST: Thim
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): 1923-1946
16b. SOCIAL SECURITY NO.: 551 38 5657
17. INFORMANT: Mrs. Mildred Harvey ADDRESS: 613 Banyon Ave. Severna Park M 21146

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extra dural hematoma, right, extensive, recent, compressing the right cerebral
DUE TO, OR AS A CONSEQUENCE OF (b): hemisphere with right uncal, temporal and tonsillar herniation.
DUE TO, OR AS A CONSEQUENCE OF (c): Congestion of lungs, marked with possible focal bronchopneumonia. Splenitis, acute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that XX(this hospital) attended the deceased from July 18 19 72 to September 9 19 84 xxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: MD DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 9-10-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. N. ATAY, M.D.
22e. ADDRESS: VA Medical Center, Perry Point, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Sept. 12 1984
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn
23d. LOCATION CITY OR TOWN: - COUNTY STATE: Baltimore, Md.
24. FUNERAL DIRECTOR NAME: Lilly & Zeiler Funeral Home, ADDRESS: 700 S. Conkling St. Baltimore, Md. 21
25a. DATE REC'D. BY REGISTRAR: SEP 14 1984
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical [illegible]

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BP________

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 84 24837

1. DECEASED NAME (TYPE OR PRINT) FIRST: NATOLE MIDDLE: G LAST: BRAIS		2a. DATE OF DEATH MONTH DAY YEAR: September 6, 1984	2b. HOUR: 6:15p M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 16 1908	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Illinois	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co. MD.
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center Perry Point, MD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Electronic Technician	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Pr.Geo.	13c. CITY OR TOWN: W.Hyattsville	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS / ZIP CODE: 2806-Jamestown Rd. 20782
14. FATHER'S NAME FIRST: Eustache MIDDLE: LAST: Brais		15. MOTHER'S MAIDEN NAME FIRST: Agnes MIDDLE: LAST: LeMieux	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 10-15-1936 10-14-1940	16b. SOCIAL SECURITY NO.: 578-03-5460	17. INFORMANT: Wanda O.Brais- above address (Wife) ADDRESS:	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Atherosclerosis of coronary artery, marked calcific

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardical hypertrophy, bi-ventricular

DUE TO, OR AS A CONSEQUENCE OF (c) Edema of lungs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that [X] (this hospital) attended the deceased from Aug 5, 19 83, to Sep 6, 19 84, that [X] (we) last saw the deceased alive on Sep 6, 19 84, and that in [X] (our) opinion death occurred on the date and hour and from the causes stated above. [X] (we) [did] [did not] view the body after death.

22b. SIGNATURE: Joseph Coudon MD	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 9-7-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH COUDON, M.D.	22e. ADDRESS: VA Medical Center, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9/11/1984	23c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln Cem.	23d. LOCATION CITY OR TOWN: Brentwood COUNTY: Pr.Geo. STATE: Md.
24. FUNERAL DIRECTOR NAME: Nalley's ~~Nally~~ Funeral HOme ADDRESS: , Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR: SEP 14 1984	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24838

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	Harry W. Clarke
2a. DATE OF DEATH MONTH DAY YEAR	September 15, 1984
2b. HOUR	9:11 PM
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Nov. 19, 1895
6. AGE (IN YEARS LAST BIRTHDAY)	88 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Rhode Island
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil MD.
10. CITY OR TOWN OF DEATH	Perry Point
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Perry Point VAMC
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Superintendant
12b. KIND OF BUSINESS OR INDUSTRY	Civil Cons.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	Harford
13c. CITY OR TOWN	Aberdeen
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS / ZIP CODE	600 Old Robin Hood/21001
14. FATHER'S NAME FIRST MIDDLE LAST	Isaac Howard Clarke
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Mathilda St. Clair
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	036 09 0613
17. INFORMANT ADDRESS	VAMC, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic obstructive lung disease

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8-1- 19 84 to 9-15- 19 84, that I (we) last saw the deceased alive on 9-15- 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	Eugene A. Jaeger
DEGREE	MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	
22c. DATE SIGNED	9/15/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	EUGENE A. JAEGER, M.D.
22e. ADDRESS	VAMC, Perry Point, Maryland
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Removal/Burial
23b. DATE	Sep. 17, 1984
23c. NAME OF CEMETERY OR CREMATORY	Cedar Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE	Jamestown, Newport, RI
24. FUNERAL DIRECTOR NAME ADDRESS	Kenneth D. Cargill Tarring Funeral Home Aberdeen, Md. 21001-3399
25a. DATE REC'D. BY REGISTRAR	SEP 19 1984
25b. REGISTRAR'S SIGNATURE	Eva Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24839

1. DECEASED NAME (TYPE OR PRINT) FIRST CARL MIDDLE J. LAST D'AUITO, SR.		2a. DATE OF DEATH MONTH DAY YEAR 9-2-84	2b. HOUR 7:40 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 8, 1913	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-	12b. KIND OF BUSINESS OR INDUSTRY Commercial Netting
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware	13b. COUNTY New Castle	13c. CITY OR TOWN Newark	13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS 3081 Old County Road 19702
14. FATHER'S NAME FIRST Modesta MIDDLE - LAST D'Auito		15. MOTHER'S MAIDEN NAME FIRST Pauline MIDDLE - LAST Natale	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 157-12-7721	17. INFORMANT Mrs. Catherine D'Auito, Newark, Del. 19702 — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Inferior Posterior Myocardial Infarction — 16 hours

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): N/A

19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1 Sept 84, 19____, to 2 Sept, 1984, that (I) (we) last saw the deceased alive on 2 Sept, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Ralph H. Wendel MD — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]		22c. DATE SIGNED 9-2-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER H. WENDEL MD	22e. ADDRESS H-46 OMEGA DR. ; NEWARK, DEL. 19713	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-5-84	23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	23d. LOCATION CITY OR TOWN — COUNTY — STATE Cemetery, Cherry Hill, Md.
24. FUNERAL DIRECTOR NAME Ralph E. Hicks — ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR SEP 5 1984	25b. REGISTRAR'S SIGNATURE Lucia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16.50M 4/82 (VRA 15, 4)

1571

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24840

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: ELLWOOD Ardell DAVIS		2a. DATE OF DEATH MONTH DAY YEAR: SEPTEMBER 2, 1984	2b. HOUR: 3:05 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 20, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Army	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Aberdeen,	YES [X] NO [ ]	66 AberdeenAve.,21001

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Matthew Davis	Evelina Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII,Korea	176-16-3746	Toshiko Davis	66 Aberdeen Ave.,21001 Aberdeen,MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) CEREBRAL THROMBOSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

CEREBRAL VASCULAR ACCIDENT, MYOCARDIAL INFARCTION, ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JUNE 14, 19 84, to SEPT. 2, 19 84, that (I) (we) last saw the deceased alive on SEPT 2, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G.E. Rayson	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GLENDON RAYSON, M.D.	VA MEDICAL CENTER, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Removal/Cremation	Aug 3,1984	Cratin and Ferris	West Chester,Chester,Penna.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Kenneth B Cay Tarring Funeral Home	33 S. Parke St., Aberdeen, Md. 21001	SEP 7 1984	Julia Gordon-Nicholson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked yes, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24841
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST John MIDDLE Wesley LAST Duker

2a. DATE OF DEATH: MONTH September DAY 21 YEAR 1984

2b. HOUR: 2:40 P M

3. SEX: Male

4. RACE: Negro

5. DATE OF BIRTH: MONTH 7 DAY 4 YEAR 1916

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Elkton, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maintence

12b. KIND OF BUSINESS OR INDUSTRY: Park & Rec.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Delaware

13b. COUNTY: New Castle

13c. CITY OR TOWN: Townsend

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET ADDRESS: 99999

14. FATHER'S NAME: FIRST Ephram MIDDLE LAST Duker

15. MOTHER'S MAIDEN NAME: FIRST Irene MIDDLE LAST Duker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Unknown (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 222-10-7185

17. INFORMANT: Edith Duker-Townsend, Delaware ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cat cell carcinoma of the lung

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/4, 19 79, to 9/22, 19 84, that (I) (we) last saw the deceased alive on 9/22, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kenneth Lewis. MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 9/25/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kenneth Lewis, M.D.

22e. ADDRESS: 12 Pennington St. Middletown De 19709

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 9/26/84

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery

23d. LOCATION: CITY OR TOWN Townsend COUNTY N.C., STATE Del.

24. FUNERAL DIRECTOR: NAME Edward McKown Lee Funeral Home ADDRESS 259 E. MAIN ST. ELK

25a. DATE REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE: Gilbert Davidson Pendell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

BP

DHMH - 16 50M 4/82 (VRA 15, 4)

A

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24842

1. DECEASED NAME (TYPE OR PRINT) FIRST Virgina MIDDLE H. LAST Fears		2a. DATE OF DEATH MONTH 9 DAY 29 YEAR 84	2b. HOUR 0245 M
3. SEX Female	4. RACE Caus.	5. DATE OF BIRTH MONTH 12 DAY 3 YEAR 13	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH EIKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD	13b. COUNTY Cecil	13c. CITY OR TOWN ~~Northeast~~ Perryville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS 176 Greenbank Road, 21903

14. FATHER'S NAME ~~XXXX~~ Dec FIRST John MIDDLE Wesley LAST Husfelt	15. MOTHER'S MAIDEN NAME ~~XXX~~ Dec FIRST Sarah MIDDLE	LAST Bolten
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 219-16-4019	17. INFORMANT C. Caballin RN ADDRESS Union Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular Tachycardia

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive HT Failure.

DUE TO, OR AS A CONSEQUENCE OF (c) Pleural effusion.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arrhythmias.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Madhu S. Saunder	DEGREE MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED 9.29.84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-3-84	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION CITY OR TOWN Ches. COUNTY City Cecil STATE Md.
24. FUNERAL DIRECTOR NAME Crouch Funeral Home ADDRESS North East, Md.		25a. DATE REC'D. BY REGISTRAR OCT 2 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24843
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JENNIE MIDDLE: L. LAST: FERGUSON		2a. DATE OF DEATH MONTH DAY YEAR: SEPTEMBER 15, 1984	2b. HOUR: a.m.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 6, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Cecil	Elkton	YES [X] NO [ ]	122 Stockton Street 21921

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas	-	Widdoes	Olga	K.	Olsen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212-18-8621	Mr. Enoch O. Ferguson	Elkton, Md. 21921

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: About 15 months
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Hypertensive cardiovascular disease with angina — Over 1 yr.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from July 1, 1976 to Sept. 15, 1984, that (I) (we) last saw the deceased alive on Sept. 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
S. Ralph Andrews	M.D.	[✓]	9/17/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
S. Ralph Andrews, M.D.	233 E. Main St., Elkton, Md. 21

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9-18-84	Gilpin Manor Memorial Park	Elkton, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks — HICKS HOME for FUNERALS	ELKTON, MD. 21921	SEP 21 1984	Lia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24844

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JOHN EARL FILLINGAME
2a. DATE OF DEATH MONTH DAY YEAR	SEPT 21, 1984
2b. HOUR	6:30A M
3. SEX	MALE
4. RACE	W
5. DATE OF BIRTH MONTH DAY YEAR	Oct 30, 1916
6. AGE (IN YEARS LAST BIRTHDAY) YRS.	67
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil County MD.
10. CITY OR TOWN OF DEATH	Elkton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Union Hospital
12a. USUAL OCCUPATION (KIND OF WORK FOR MOST OF WORKING LIFE)	Retired Chef
12b. KIND OF BUSINESS OR INDUSTRY	Chef
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Delaware
13b. COUNTY	N.C.
13c. CITY OR TOWN	Townsend
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	Frederick Lodge
14. FATHER'S NAME FIRST / MIDDLE / LAST	Fred Fillingame
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Margaret Seward
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes
(IF YES, GIVE WAR OR DATES)	W.W. II
16b. SOCIAL SECURITY NO.	221-05-9141
17. INFORMANT	Geneva Fillingame-Townsend, Del
ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May 5th, 1980, to AUG 22nd 1984, that (I) (we) last saw the deceased alive on SEPT 21 at 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: Kenneth Lewis, MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 9/22/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS MD.

22e. ADDRESS Pennington St, Middletown Del.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 9/24/84

23c. NAME OF CEMETERY OR CREMATORY Townsend Cem.

23d. LOCATION CITY OR TOWN / COUNTY / STATE Townsend - N.C. Del.

24. FUNERAL DIRECTOR Robert C. Hutchison - Middletown, Del.

25a. DATE REC'D. BY REGISTRAR SEP 25 1984

25b. REGISTRAR'S SIGNATURE Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within [illegible] days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76 (VR A 15 (4))

A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24845

1. DECEASED NAME (TYPE OR PRINT) FIRST: EARL MIDDLE: W. LAST: FITZGERALD		2a. DATE OF DEATH MONTH DAY YEAR: Sept 14 1984	2b. HOUR: 11:32 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 9 1929	6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Perry Point VAMC	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Army	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 1544 Perryman Rd., 21001

14. FATHER'S NAME FIRST: Frank MIDDLE: LAST: Fitzgerald		15. MOTHER'S MAIDEN NAME FIRST: Bessie MIDDLE: LAST: Hess	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 227 28 8301	17. INFORMANT: Margaret Fitzgerald	ADDRESS: 1544 Perryman Rd., 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	27 Min
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart Failure	1 year
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease	8 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from September 14 19 84, to September 14 19 84, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE: S. Phillips	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: 9/14/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. PHILLIPS, M.D.	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Sep. 17, 1984	23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gdns.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Aberdeen, Harford, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring F. H. Aberdeen, Md 21001 (Kenneth B. Tarring)		25a. DATE REC'D. BY REGISTRAR: SEP 19 1984	25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

Item #6-fg598-12/20/84 jp

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24846

1. DECEASED NAME (TYPE OR PRINT) FIRST: EDWARD MIDDLE: Jacob LAST: FREED		2a. DATE OF DEATH MONTH DAY YEAR: September 4, 1984	2b. HOUR: 5:45am M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 20, 1928	6. AGE (IN YEARS LAST BIRTHDAY): ~~58~~ 56 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Contractor	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Havre de Grace	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 616 No. Adams St., 21078			

14. FATHER'S NAME FIRST: Hilbert MIDDLE: LAST: Freed		15. MOTHER'S MAIDEN NAME FIRST: Florence MIDDLE: LAST: UNK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 191-20-3010	17. INFORMANT: Carol Freed 616 N. Adams St., Havre de Grace MD 21078 ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic lung cancer

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that [X] (this hospital) attended the deceased from August 9, 19 84, to September 4, 19 84 XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 9-4-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABDUL KARIM, M.D.		22e. ADDRESS: VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Sep. 6, 1984	23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Havre de Grace, Harford, MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, Aberdeen, Md. 21001-3399		25a. DATE REC'D. BY REGISTRAR: SEP 11 1984	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and act.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 84 24847

1. DECEASED NAME (TYPE OR PRINT): FRANCES M. GAWINSKI
2a. DATE OF DEATH: SEPT 6 1984
2b. HOUR: 7:15 AM
3. SEX: F
4. RACE: CAUCASIAN
5. DATE OF BIRTH: NOV 22 1890
6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): POLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: CALVERT CO ~~CECIL~~ MD.
10. CITY OR TOWN OF DEATH: CALVERT MD.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CALVERT MNR NURS. HOME INC
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Cecil
13c. CITY OR TOWN: ELKTON
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 519 MIDDLE ROAD 21921

14. FATHER'S NAME: ANTHONY KORZIENSKI
15. MOTHER'S MAIDEN NAME: ANGELA RADZIEWICZ
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 221-32-6814
17. INFORMANT: AGNES C. BARCZEWSKI
ADDRESS: 519 middle River Rd. Elkton md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Athero Sclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Dementia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12.30 1983 to 9.6 1984, that (I) (we) last saw the deceased alive on July 12 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Sheelmohan S. Sachdev
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 9.7.84.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): SHEELMOHAN S. SACHDEV
22e. ADDRESS: Bow St. ELKTON MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Sept. 10, 1984
23c. NAME OF CEMETERY OR ~~CREMATORY~~: CATHEDRAL
23d. LOCATION: CITY OR TOWN: Wilmington COUNTY: NewCastle STATE: Del.

24. FUNERAL DIRECTOR: NAME: Edward McKeown ADDRESS: Gee Funeral Home 259 E. MAIN St. ELKTON MD
25a. DATE REC'D BY REGISTRAR: SEP 11 1984
25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 copy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH-16 25M (VRA 15, 4) 1/79

A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24848

1. DECEASED NAME (TYPE OR PRINT): FIRST Gertrude MIDDLE C LAST Graham
2a. DATE OF DEATH: MONTH 9 DAY 11 YEAR 84
2b. HOUR: 1548 M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH AUGUST DAY 30 YEAR 1904
6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.
10. CITY OR TOWN OF DEATH: Elkton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Cecil
13c. CITY OR TOWN: Elkton
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 264 Muddy Lane 21921

14. FATHER'S NAME: FIRST ---- MIDDLE LAST Ruhfuss
15. MOTHER'S MAIDEN NAME: FIRST Unknown MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 171-10-3282
17. INFORMANT: Mr. Daniel I. Graham, Elkton, Md. 21921 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure — Approx 1 week
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Renal Disease — over 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~the hospital~~) attended the deceased from April 7, 19 88, to Sept. 11, 19 84, that (I) (~~we~~) last saw the deceased alive on Sept. 11, 19 84, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~and~~) (did not) view the body after death.
22b. SIGNATURE: S Ralph Andrews
DEGREE: M.D
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 9/11/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): S RALPH ANDREWS MD
22e. ADDRESS: 233 E. Main St. Elkton Md 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 9-15-84
23c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception
23d. LOCATION: CITY OR TOWN Cemetery, COUNTY Cherry Hill, STATE Md.
24. FUNERAL DIRECTOR: NAME Donald S. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. 21921
25a. DATE REC'D. BY REGISTRAR: SEP 21 1984
25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24849

1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: Robert LAST: Hagy		2a. DATE OF DEATH MONTH DAY YEAR: September 6, 1984	2b. HOUR: a.m.
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 3 6 '20	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Fork Lift Operator	12b. KIND OF BUSINESS OR INDUSTRY: Chrysler Corp

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	North East	YES [ ] NO [X]	413 Old Bay View Road 21901

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Wiley	E.	Hagy	Martha	Jane	McFarlane

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	224-24-6242	Mrs. Mary C. Hagy	North East, Maryland 21901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary insufficiency

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic obstructive pulmonary disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 24 19 77, to Sept. 6 19 84, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 8/7/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): HIYAMA KAWA M.D. — 22e. ADDRESS: 319 So. Union Ave. Havre de Grace Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9-9-84	Union Cemetery	Union, Cecil Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks	HICKS HOME for FUNERALS, ELKTON, MD. 21921	SEP 11 1984	Julia Davidson-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

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B

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84

24850
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DAVID MIDDLE: LAST: HILTON

2a. DATE OF DEATH MONTH DAY YEAR: September 27, 1984

2b. HOUR: 8:35am

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH: May DAY: 26 YEAR: 1902

6. AGE (IN YEARS LAST BIRTHDAY): 82 yrs. YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Massachusetts

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Perry Point, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrician

12b. KIND OF BUSINESS OR INDUSTRY: --------

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Florida

13b. COUNTY: Pinellas

13c. CITY OR TOWN: St. Petersburg

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS / ZIP CODE: 5150 10th Avenue 33710

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14. FATHER'S NAME FIRST: Harry MIDDLE: ---- LAST: Hilton

15. MOTHER'S MAIDEN NAME FIRST: Bessie MIDDLE: ------ LAST: Casey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 3/20 - 3/22

16b. SOCIAL SECURITY NO.: 091-16-6945

17. INFORMANT ADDRESS: V.A.M.C., Perry Point, Maryland 21902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Cardio-respiratory arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(c): Right lower lobe pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that X (this hospital) attended the deceased from November 23 19 81 to September 27 19 84 XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Julian Ocejo MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 9-27-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JULIAN OCEJO, M.D.

22e. ADDRESS: VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Oct. 2,1984

23c. NAME OF CEMETERY OR CREMATORY: Wadsworth Cemetery

23d. LOCATION CITY OR TOWN: Danvers COUNTY: Essex STATE: Mass.

24. FUNERAL DIRECTOR: [illegible] Patterson + Son Perryville, Md 21903

25a. DATE REC'D. BY REGISTRAR: OCT 3

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 50M 4/83
(VRA 15, 4)

Items 18-22a 11/1/84 mtb F#597

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 84 24851

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: George W. Jackson		2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR: 9-24 1984	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 19, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 9-24 1984	2d. HOUR: 6:00 p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County, MD.
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Veterans Administration Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinist	12b. KIND OF BUSINESS OR INDUSTRY: construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Perry Point	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: Veterans Administration Hosp.
14. FATHER'S NAME FIRST / MIDDLE / LAST: John S. Jackson			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Ella D. Phillips	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 234-42-9317	17. INFORMANT: Blaine C. Jackson	ADDRESS: 7512 Dunstan St., Springfield, Va. 22151

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia, Severe

~~Blunt Trauma to Head with complications~~

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Chronic Organic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Dennis F. Smyth M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9-25-84

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10-5-84	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington, Virginia
24. FUNERAL DIRECTOR NAME / ADDRESS: Loudoun Funeral Chapel, Leesburg, Virginia 22075		25a. DATE REC'D. BY REGISTRAR: OCT 8 1984	25b. REGISTRAR'S SIGNATURE: Julia Davidson Ramsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 4 8 5 2

A

1. DECEASED NAME (TYPE OR PRINT) FIRST: LLOYD MIDDLE: Orville LAST: JENSEN

2a. DATE OF DEATH MONTH DAY YEAR: September 4, 1984

2b. HOUR: 11:30am

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: March 23, 1920

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Michigan

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Perry Point, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Officer

12b. KIND OF BUSINESS OR INDUSTRY: US Army

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 507 Paradise Road/21001

14. FATHER'S NAME FIRST: Jens MIDDLE: T. LAST: Jensen

15. MOTHER'S MAIDEN NAME FIRST: Louise MIDDLE: LAST: Hjort

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WWII Korea

16b. SOCIAL SECURITY NO.: 371-18-6207

17. INFORMANT: Annice C. Jensen, ADDRESS: 507 Paradise Rd., Aberdeen, MD 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic heart disease w/coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that X (this hospital) attended the deceased from August 7 19 84 to September 4 19 84 ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: MD.

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 9-4-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. N. ATAY, M.D.

22e. ADDRESS: VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Sep. 7, 1984

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION CITY OR TOWN, COUNTY, STATE: Arlington, Arlington, Virginia

24. FUNERAL DIRECTOR NAME: Tarring Funeral Home, ADDRESS: Aberdeen, Md. 21001-3399

25a. DATE REC'D BY REGISTRAR: SEP 11 1984

25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [illegible] with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 [illegible] any injury, or other traumatic event, the medical [illegible]

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 84 24853

1. DECEASED NAME (TYPE OR PRINT): FIRST EDNA MIDDLE V LAST JONES

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 9 DAY 8 YEAR 84 19

2b. HOUR M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Jan. DAY 22 YEAR 13

6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 9 DAY 8 YEAR 84 19

2d. HOUR 9:50a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Coubty MD.

10. CITY OR TOWN OF DEATH: Northeast

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 112 Harvey Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Waitress

12b. KIND OF BUSINESS OR INDUSTRY: Rest.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: North East

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS: 112 Harvey St. 21901

14. FATHER'S NAME: FIRST John MIDDLE LAST Eveland

15. MOTHER'S MAIDEN NAME: FIRST Edna MIDDLE LAST Roberts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-16-3818

17. INFORMANT: Patti Carsella ADDRESS: 8534 W. Catalpa Chicago, Ill. 60656

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intracerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? (HEAD ONLY) YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, (HEAD ONLY) Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Margarita Ann Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9-9-84

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 9-11-84

23c. NAME OF CEMETERY OR CREMATORY: North East Meth.

23d. LOCATION CITY OR TOWN North East COUNTY Cecil STATE Md.

24. FUNERAL DIRECTOR NAME: Couch Funeral Home ADDRESS North East, Md.

25a. DATE REC'D. BY REGISTRAR: SEP 11 1984

25b. REGISTRAR'S SIGNATURE: Celia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24854

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPH MIDDLE: F. LAST: KEMETHER		2a. DATE OF DEATH MONTH DAY YEAR: SEPTEMBER 22, 1984	2b. HOUR: a.m.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 28, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Repairman-	12b. KIND OF BUSINESS OR INDUSTRY: General Motors Corp.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Cecil	Elkton	YES [ ] NO [X]	25 Weed Lane 21921

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	-	Kemether	Reba	E.	Jewell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		169-18-0601	Mrs. Emma B. Kemether	Elkton, Md. 21921

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I/this hospital) attended the deceased from 6 19 68, to 9/22 19 84, that (I/we) last saw the deceased alive on 9/22 19 84, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
Joseph G. Lanzi		9-26-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Joseph G. Lanzi, M.D.	721 Bridge Street, Elkton, Md. 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9-27-84	Bethel Cemetery	Chesapeake City, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HICKS HOME for FUNERALS, ELKTON, MD. 21921	OCT 1 1984	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For 4 months retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or death

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

26 X

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 248 55
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Ruth Owens Knauss		2a. DATE OF DEATH MONTH DAY YEAR: September 3 1984	2b. HOUR: 5:30 PM
3. SEX: Famale	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 8 1916	6. AGE (IN YEARS LAST BIRTHDAY): 68 yrs. YRS. / IF UNDER 1 YEAR: MONTHS DAYS / IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Port Deposit	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 85 Burlin Road - Residence	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: B.N.T.C.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Cecil	Port Deposit	YES [ ] NO [X]	85 Burlin Road 21904

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Benjamin Harold Owens	Lillie Mae Craig

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	------	218/40/4576	Robert D. Knauss, Sr.	Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO-RESPIRORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF (b) ENDOMETRIAL CANCER

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug. 18, 19 84 to Sept. 3, 19 84 that (I) (we) last saw the deceased alive on Aug. 23 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Yogish A. Patel	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	Sept. 4, 1984

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Yogish Patel, MD.	Stanton Medical Bldg., Wilmington, Delaware

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Sept. 5, 1984	Cratin & Ferris Crematory	West Chester Chester Penn.

24. FUNERAL DIRECTOR (OR AUTHORIZED AGENT)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md.	SEP 11 1984	Julia Davidson-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH-16 20M (VRA 15, 4) 7/78

B

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 4 8 5 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALBERT MIDDLE: LAST: KUSTER
2a. DATE OF DEATH MONTH DAY YEAR: September 12, 1984
2b. HOUR: 2:45am
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH MONTH DAY YEAR: Sept. 5 1899
6. AGE (IN YEARS LAST BIRTHDAY): 85 yrs. YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Holland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ XX WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Perry Point, Md.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Unknown
12b. KIND OF BUSINESS OR INDUSTRY: Unknown

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Cecil
13c. CITY OR TOWN: Perry Point
13d. INSIDE CITY LIMITS? YES ☒ XX NO ☐
13e. STREET ADDRESS / ZIP CODE: V.A.M.C. 21902
14. FATHER'S NAME FIRST MIDDLE LAST: Unknown
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
(IF YES, GIVE WAR OR DATES): W.W. I
16b. SOCIAL SECURITY NO.: 215-56-2496
17. INFORMANT ADDRESS: V.A.M.C., Perry Point, Maryland 21902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforated gastric ulcer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary embolis
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that XX (this hospital) attended the deceased from June 30, 1925 to September 12 1984 XXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Roy W. Chesnut, Jr. MD DEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 9-12-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROY W. CHESNUT, M.D.
22e. ADDRESS: VA Medical Center, Perry Point, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Sept.17,1984
23c. NAME OF CEMETERY OR CREMATORY: Quantico Nat'l Cem.
23d. LOCATION CITY OR TOWN: Quantico COUNTY: Prince William STATE: VA.
24. FUNERAL DIRECTOR: Lee A. Patterson & Son
Lee A. Patterson & Son, Perryville, Md.
25a. DATE REC'D. BY REGISTRAR: SEP 20 19[illegible]
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

27 23 35 070 1 1 9 1

BP________

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 84 24857

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Vincent S. Lukas		2a. DATE OF DEATH MONTH DAY YEAR: September 2, 1984	2b. HOUR: 3:30P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 23, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Coast Guard

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 1001 Rockville Pike #921 20852

14. FATHER'S NAME FIRST MIDDLE LAST: Matthew J. Lukas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Mary Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	WW II & Korea	16b. SOCIAL SECURITY NO.: 150 10 2160	17. INFORMANT: VAMC, Perry Point, Maryland — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE, CVA'S

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (X) (this hospital) attended the deceased from 8-27- 19 84, to 9-2- 19 84, that (X) (we) last saw the deceased alive on 9-2- 19 84 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (XXX) (not) view the body after death.

22b. SIGNATURE: Glendon Rayson	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 9-2-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GLENDON RAYSON, M.D.	22e. ADDRESS: VAMC, Perry Point, Maryland	

23a. BURIAL, CREMATION, REMOVAL: Cremation	23b. DATE: 9/6/84	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION: Suitland, Maryland STATE
24. FUNERAL DIRECTOR NAME: TYSON FUNERAL HOME, ROCKVILLE, MD — ADDRESS: 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR: SEP 10 1984	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 indicates injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24353
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ETHEL	H.	MONGER	9-24-84	10:10 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	12 26 12	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		CECIL MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun	8 RED PUMP Rd.	HOUSEWIFE	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Md.	Cecil	Rising Sun		8 RED Pump Rd. 21911

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
DAVID	D.	HANNA	LAURA		HESS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	219-16-8164	OTIS MONGER	8 RED PUMP Rd. RISING SUN Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (c) SIGMOID CARCINOMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
11/22/83	OBSTRUCTING SIGMOID CARCINOMA	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
	NONE 19	NONE

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
NONE	NONE	

22a. I certify that (I) (this hospital) attended the deceased from 8/15/ 19 84, to 8/21/ 19 84, that (I) (we) last saw the deceased alive on 8/21/84 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William J. Murphy DO	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	9/25/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
WILLIAM F. MURPHY D.O.	303 N. 3rd ST OXFORD PA. 19363

23a. BURIAL, CREATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9-27-84	Brookview Cemetery	Rising Sun Cecil Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R.T. FOARD FUNERAL HOME	Rising Sun Md	SEP 28 1984	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24859
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST ALBERT MIDDLE J. LAST MOORE

2a. DATE OF DEATH MONTH DAY YEAR 9-24-84

2b. HOUR M

3. SEX M

4. RACE W

5. DATE OF BIRTH MONTH 12 DAY 30 YEAR 03

6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD

7b. CITIZEN OF WHAT COUNTRY? U.S.A

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.

10. CITY OR TOWN OF DEATH ELKTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET GOVT

12b. KIND OF BUSINESS OR INDUSTRY LABOR

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD

13b. COUNTY CECIL

13c. CITY OR TOWN CHESAPEAKE CITY

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 405 GEORGE 21915

14. FATHER'S NAME FIRST JOHN MIDDLE LAST MOORE

15. MOTHER'S MAIDEN NAME FIRST MOLLIE MIDDLE LAST BOOTS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 109-12-4422

17. INFORMANT VIOLET L. MOORE ADDRESS CHESAPEAKE CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure & Pul. Edema

DUE TO, OR AS A CONSEQUENCE OF (c) COPD. - D. Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept. 22, 19 84, to Sept. 24, 19 84, that (I) (we) last saw the deceased alive on Sept. 24, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED Sept. 24/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERNESTO M. ABLANG

22e. ADDRESS 200 BOW ST ELKTON MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE 9-27-84

23c. NAME OF CEMETERY OR CREMATORY BETHEL

23d. LOCATION CITY OR TOWN CHESAPEAKE CITY COUNTY CECIL STATE MD

24. FUNERAL DIRECTOR NAME R.T. FOARD FUNERAL HOME ADDRESS CHESAPEAKE CITY MD

25a. DATE REC'D. BY REGISTRAR SEP 26 1984

25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

10-6

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24860
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROSCOE MIDDLE: L LAST: PETERS		2a. DATE OF DEATH MONTH 9 DAY 15 YEAR 84	2b. HOUR 1200 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH June DAY 14, YEAR 1903	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gilmer Co., W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Farmer &	12b. KIND OF BUSINESS OR INDUSTRY: Storekeeper

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Cecil	Rising Sun	YES ☒ NO ☐	289 Chandlee Road 21911

14. FATHER'S NAME FIRST: Theodore MIDDLE: Peterson LAST:		15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: LAST: Lyons	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO. 233-14-3370	17. INFORMANT: Thelma L. Peters ADDRESS: 289 Chandlee Rd, Rising Sun, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cancer, metastatic

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19__, to Sept 15, 19 84, that (I) (~~we~~) last saw the deceased alive on Sept 15, 19 84, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Jo Ann Rosenfeld DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 9-15-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jo Ann Rosenfeld, M.D.	22e. ADDRESS: Cecilton, Md. 21913	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9-20-84	23c. NAME OF CEMETERY OR CREMATORY: Carter Cemetery	23d. LOCATION CITY OR TOWN: Vadis COUNTY: Lewis STATE: W. Va.
24. FUNERAL DIRECTOR NAME: GEE FUNERAL HOME, P.A. ADDRESS: Elkton, Md.		25. DATE REC'D BY REGISTRAR: SEP 18 1984	26. REGISTRAR'S SIGNATURE: Vicki Davidson-Randell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24861

1. DECEASED NAME (TYPE OR PRINT) FIRST John MIDDLE Manning LAST Redd ,Sr.

2a. DATE OF DEATH MONTH September DAY 16 YEAR 1984

2b. HOUR 8:15P M

3. SEX Male

4. RACE White

5. DATE OF BIRTH MONTH Sept. DAY 28, YEAR 1919

6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Perry Point, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Factory worker

12b. KIND OF BUSINESS OR INDUSTRY: ——

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Rt #1

13b. COUNTY Lancaster

13c. CITY OR TOWN Peach Bottom

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS & ZIP CODE Route #1 17563

14. FATHER'S NAME FIRST Father MIDDLE ——— LAST Redd

15. MOTHER'S MAIDEN NAME FIRST Nancy MIDDLE LAST Webb

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes

(IF YES, GIVE WAR OR DATES) Navy

16b. SOCIAL SECURITY NO. 243 28 7663

17. INFORMANT ADDRESS: VAMC, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic obstructive lung disease

DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of lung

DUE TO, OR AS A CONSEQUENCE OF (c) General arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 5-13- 19 84 to 9-16- 19 84 that I (we) last saw the deceased alive on 9-16- 19 84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE Eugene A. Jaeger

DEGREE M.D.

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED 9-16-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE A. JAEGER, M.D.

22e. ADDRESS VAMC, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE Sept 21 1984

23c. NAME OF CEMETERY OR CREMATORY Hope Episcopal Cem. 21078

23d. LOCATION CITY OR TOWN Manheim, Pa. COUNTY Lancaster STATE

24. FUNERAL DIRECTOR NAME Mitchell Funeral Home, Havre de Grace, Md.

25a. DATE REC'D. BY REGISTRAR SEP 21 1984

25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 24362

1. DECEASED NAME (TYPE OR PRINT) FIRST: NELL MIDDLE: B. LAST: SHUMAKER

2a. DATE OF DEATH MONTH DAY YEAR: 09-22-84

2b. HOUR: 10:27 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Dec. 6 1894

6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS. IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House Wife Ret.

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: North East

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 852 Brickmetting House Rd. 21901

14. FATHER'S NAME FIRST MIDDLE LAST: James M. Blevins

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Jennie E. Perkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 243-58-6627

17. INFORMANT: Mrs. Elizabeth Reider (Daughter) ADDRESS: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute MI

DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Stenosis

DUE TO, OR AS A CONSEQUENCE OF (c) D.M. Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jayantilal K. Patel

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 9/22/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAYANTILAL K PATEL MD

22e. ADDRESS: 123 Singerly Ave Elkton MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Sept. 27, 84

23c. NAME OF CEMETERY OR CREMATORY: Scott Blevins Cem.

23d. LOCATION CITY OR TOWN: Crumpler COUNTY: Ash STATE: N.C.

24. FUNERAL DIRECTOR NAME: Richard L. Goecke ADDRESS: Rising Sun, Md.

25a. DATE REC'D. BY REGISTRAR: SEP 26 1984

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82 (VRA 15, 4)

A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 24863

1. DECEASED NAME (TYPE OR PRINT): FIRST Elizabeth MIDDLE P. HILLIPS LAST Speers

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH 9 DAY 25 YEAR 1984

2b. HOUR M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH APR. DAY 3, YEAR 1920

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH 9 DAY 25 YEAR 1984

2d. HOUR 1223 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CONN.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Warwick

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 355 Worsell Manor Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DEPT OF HEALTH

12b. KIND OF BUSINESS OR INDUSTRY: STATE OF MAINE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: CECIL

13c. CITY OR TOWN: WARWICK

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 355 WORSELL MANOR RD. 21912

14. FATHER'S NAME: ALFRED N. PHILLIPS

15. MOTHER'S MAIDEN NAME: MARY SMITH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 093-24-8662

17. INFORMANT: RONALD T. SPEERS ADDRESS: HUSBAND SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple myeloma

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: J. Vitale M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED 9-25-84

EXAMINER'S NAME (TYPE OR PRINT): Juan C. Gonzalez-Vitale, MD ADDRESS: Union Hospital, Elkton, MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 9/30/84

23c. NAME OF CEMETERY OR CREMATORY: GLENSIDE CEMETERY

23d. LOCATION CITY OR TOWN: WINTHROP, KENNEBEC, MAINE

24. FUNERAL DIRECTOR NAME: FELLOWS FUNERAL HOME ADDRESS: 226 E. MAIN ST. CECILTON, MD 21913

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE: Gertie Davidson Rand

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24864
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: NELLIE MIDDLE: — LAST: TRICE

2a. DATE OF DEATH MONTH DAY YEAR: 9/12/84

2b. HOUR: 0050 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Aug 7 1898n

6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.

10. CITY OR TOWN OF DEATH: ELKTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machine Operater

12b. KIND OF BUSINESS OR INDUSTRY: Fiber

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Delaware

13b. COUNTY: New castle

13c. CITY OR TOWN: Newark

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 38½ Chapel St.

14. FATHER'S NAME FIRST: Willaam MIDDLE: E. LAST: Todd

15. MOTHER'S MAIDEN NAME FIRST: Indiana MIDDLE: — LAST: Todd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 221-07-5922A

17. INFORMANT: Elva Jester ADDRESS: 301 Ashley Pl. Newark De.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY EMBOLISM

DUE TO, OR AS A CONSEQUENCE OF (b) AMPUTATION (R) LEG

DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OSTEOMYELITIS & GANGRENE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): OLD AGE

19a. DATE OF OPERATION: 9-11-84

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: GANGRENE (R) LEG

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-7, 19 84, to 9-11, 19 84, that (I) (we) last saw the deceased alive on 9-11-84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L. A. Mein, M.D. P.A. DEGREE

ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 9-12-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LEO A. NATERA M.D.

22e. ADDRESS: 206 BOW ST ELKTON MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Sept. 15 1984

23c. NAME OF CEMETERY OR CREMATORY: Gracelawn Park

23d. LOCATION CITY OR TOWN: Farnhurst COUNTY: N.C. STATE: De.

24. FUNERAL DIRECTOR NAME: Donald D. Hicks
HICKS HOME for FUNERALS, ELKTON, MD.21921

25a. DATE REC'D. BY REGISTRAR: OCT 1 1984

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

84 24865
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nina MIDDLE: C LAST: White

2a. DATE OF DEATH MONTH DAY YEAR: 9/11/84

2b. HOUR: 2055 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Sept. 7, 1905

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.

10. CITY OR TOWN OF DEATH: ELKTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Delaware

13b. COUNTY: New Castle

13c. CITY OR TOWN: Wilmington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 3007 West Street 99999

14. FATHER'S NAME FIRST: William MIDDLE: LAST: Shannon

15. MOTHER'S MAIDEN NAME FIRST: Anna MIDDLE: Mae LAST: Shannon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 222 22 8203

17. INFORMANT ADDRESS: 210 Hollywood Beach Rd., Chesapeake City, Md.
Charles G. White, Jr. (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8-6, 19 84, to 9-11, 19 84, that (I) (we) last saw the deceased alive on 9-11-84, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: JoAnn Rosenfeld MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 9-14-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JoAnn Rosenfeld MD

22e. ADDRESS: Cecilton, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 9/15/84

23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Wilmington, N. C., Del.

24. FUNERAL DIRECTOR AND ADDRESS: Albert J. McCrery, III, 3924 Concord Pk. Wilm., Del.

25. DATE REC'D BY REGISTRAR: SEP 21 1984

26. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP ____

DHMH - 16 50M 4/82
(VRA 15, 4)

18-22a 1/14/85 mtb F#599

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24866

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CHRISTOPHER M. WILLIAMS		2a. DATE OF DEATH KNOWN [XX] ESTIMATED [ ] MONTH DAY YEAR: 9-8-84	2b. HOUR: M
3. SEX: Male	4. RACE: Caucasion	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.; IF UNDER 1 YR. MONTHS: 1; DAYS; IF UNDER 24 HRS. HOURS; MIN.
2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 9-8-84	2d. HOUR: 9:40 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Hampshire	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ----------	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: N.H.	13b. COUNTY	13c. CITY OR TOWN: Manchester	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: 1037 Elm St. Apt. 101			
14. FATHER'S NAME FIRST / MIDDLE / LAST: Marc Williams		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Dr. Juan Gondez-Vitale ADDRESS: Elkton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cleft palate

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9-9-84

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn STreet

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removel	23b. DATE: 9-20-84	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR: SEP 21 1984	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP881

DHMH - 17
(VR-A15 ME (5))
20M 4/82